Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SIERRA MEDICAL CENTER PO BOX 809053 DALLAS TX 75380-9053	MFDR Tracking #:	M4-03-2561-01
Respondent Name and Box #: American Home Assurance Co. Box #: 19		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Carrier paid TWCC Fee Guideline amount. Fee guideline does not apply to outpatient facility charges."… "Carrier changed CPT code to 80050 and paid at fee guideline for that code."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $1,106.75
3. Hospital Bill
4. EOB
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The carrier maintains that it has paid all reasonable, necessary and related charges in conformity with the Statute, Rules and the Medical Fee Guidelines. The charges were reduced as exceeding fair and reasonable, usual and customary and/or fee schedule. The facility has offered no proof of the need for additional reimbursement."

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
1/31/2002	1, 2	Emergency services with radiological and laboratory studies	$1,106.75	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective October 7, 1991 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - 1 – "(F) The charge for this procedure exceeds fair and reasonable."
   - 2 – "The charge for this procedure exceeds the fee schedule or usual and customary allowance"

2. This dispute relates to outpatient emergency services including laboratory and radiological studies performed in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(a)(3) and §134.401(a)(5), effective August 1, 1997, 22 TexReg 6264, which provide that such services shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific services.
3. Division Rule at 28 TAC §134.1(f) effective October 7, 1991, 16 TexReg 5210, requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates"…
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division Rule at 28 TAC §133.307(e)(2)(B), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB)"… "relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB". This request for medical fee dispute resolution was received by the Division on January 24, 2003. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Nor has the requestor provided convincing evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has failed to submit the request in the form, format and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(e)(2)(B).
6. Division rule at 28 TAC §133.307(g)(3)(A), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including "documentation of the request for and response to reconsideration (when a provider is requesting dispute resolution on a carrier reduction or denial of a medical bill) or, if the carrier failed to respond to the request for reconsideration, convincing evidence of the carrier's receipt of that request" This request for medical fee dispute resolution was received by the Division on January 24, 2003. Pursuant to §133.307(g)(3), the Division notified the requestor on February 10, 2003 to send the additional required documentation. Review of the submitted evidence finds that the requestor has not provided documentation of the insurance carrier's response to the request for reconsideration or convincing evidence of the carrier's receipt of that request. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(A).
7. Division rule at 28 TAC §133.307(g)(3)(C), effective January 1, 2003, 27 TexReg 12282; and applicable to disputes filed on or after January 1, 2003 requires the requestor to send additional documentation relevant to the fee dispute including "a statement of the disputed issue(s) that shall include: (i) a description of the healthcare for which payment is in dispute, (ii) the requestor's reasoning for why the disputed fees should be paid or refunded, (iii) how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues, and (iv) how the submitted documentation supports the requestor position for each disputed fee issue." This request for medical fee dispute resolution was received by the Division on January 24, 2003. Pursuant to §133.307(g)(3), the Division notified the requestor on February 10, 2003 to send the additional required documentation. Review of the submitted documentation finds that the requestor did not state its reasoning for why the disputed services should be paid; or how the Texas Labor Code and Division rules impact the disputed fee issues; or how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C).
8. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement"… This request for medical fee dispute resolution was received by the Division on January 24, 2003. Pursuant to §133.307(g)(3), the Division notified the requestor on February 10, 2003 to send the additional required documentation. The requestor did not submit a position statement for consideration in this dispute. Review of the submitted documentation finds that the requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated. The requestor's rationale for increased reimbursement from the *Table of Disputed Services* states that "Carrier paid TWCC Fee Guideline amount. Fee guideline does not apply to outpatient facility charges."… "Carrier changed CPT code to 80050 and paid at fee guideline for that code" but does not further discuss or explain how the amount in dispute was calculated or arrived at. The requestor does not explain how it determined that payment of the amount in dispute would result in a fair and reasonable reimbursement for the services in dispute. The requestor did not submit convincing evidence to support the rationale for increased reimbursement. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the statutory requirements and Division rules. The request for additional reimbursement is not supported.

9. Although the requestor has not stated explicitly what method should be used to determine a fair and reasonable rate of reimbursement, review of the requestor's *Table of Disputed Services* finds that the amount in dispute is the same as the amount billed, less the amount previously paid for each service. However, the Division has determined that a reimbursement methodology based upon payment of the hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that:

   "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

   Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment in the amount sought by the requestor would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

10. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(e)(2)(B), §133.307(g)(3)(A), §133.307(g)(3)(C) and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.